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State Health Reform: How to Fund a Statewide Health Insurance Exchange

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Seeking to establish a framework for a consumer-centered health insurance marketplace, many state policymakers are considering the concept of a statewide health insurance exchange.[1] Similar to a stock market or farmers market, a health insurance exchange serves as a market organizer and central clearinghouse for buying and selling health insurance and managing related information and financial transactions. An exchange performs the administrative functions associated with individuals choosing and paying for health insurance within the context of employer-sponsored coverage, thereby allowing individuals to obtain portable individual health insurance within the federal-law construct of "employer-sponsored" plans. As such, an exchange functions like a common human resources department for participating employers and their workers.

Creating a Hybrid Market. The first step is for a state, using its power to regulate commercial insurance, to create a new hybrid insurance market that combines the most attractive features of the now separate individual and group markets. Specifically, a new hybrid market would offer participating workers broad choice of major medical insurance products, and coverage would be individually owned and portable. Those are the most attractive features of the current individual market that traditional employer group plans cannot offer. At the same time, coverage would be "guaranteed issued" and would not be individually underwritten, and an individual's future coverage options would not diminished if his or her health status declines. In addition, individuals would be able to use pre-tax dollars to purchase coverage and even out-of-pocket medical care through FSA, HSA, and HRA arrangements. These are the most attractive features of the current employer group market that are not available—either at all or to the same extent—in the current individual market.

Having authorized the sale of the new hybrid insurance products, the state can charter a health insurance exchange as the market organizer for the new arrangement. An employer can then voluntarily sign up to designate the exchange (and all the insurance products sold through it) as its employer group "plan" for its workers. Because this arrangement qualifies as an employer-sponsored "plan" for purposes of federal law, the employer's workers could purchase coverage of their choice through the exchange on a pre-tax basis.

A state might also opt to further leverage the exchange mechanism by folding its current individual insurance market into the new hybrid market administered by the exchange or by using the exchange to administer premium support contributions to supplement individual and employer funding for one or more categories of low-income residents. Massachusetts's exchange has taken on both of these roles.[2]

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Note that the basic design of an exchange does not include any policymaking, regulatory, or adjudicative functions. While it is possible for a state to assign its exchange one or more of those governmental functions (as in Massachusetts), state lawmakers pursuing such an approach would be well advised to treat those functions as separate within the exchange and to budget for them separately as well. Because the primary purpose of an exchange is to provide administrative services for participating individuals, employers and insurers, it is fair to charge participants a fee to cover the cost of those services. However, it would be unfair to burden only exchange participants with the additional costs incurred by an exchange performing what are essentially broader, governmental functions. Thus, if a state wants to "contract out" to its exchange the job of performing certain functions on behalf of the general public—for example, conducting enrollment and eligibility verification for public assistance programs—the fair approach is to pay for those services out of general state tax revenues; the same as if they were retained in an existing state government agency.

Financial Components. In designing a state health insurance exchange, lawmakers need to plan for five main financial components:

1. **Core Operations:** In its basic form—that is, without responsibility for any governmental functions—an exchange will need to operate several administrative systems. First, it will need to bill and collect premium payments from employers, individuals, and perhaps government premium support programs. This system should include a payroll-withholding feature for the ease and convenience of participating employers and their workers. The premium payments will then need to be transmitted to the insurers offering coverage through the exchange, in accordance with the coverage elections made by participating individuals. The exchange will also need to track commissions owed and paid to insurance agents and brokers who bring groups or individuals to the exchange. In addition, the exchange will need to prepare and distribute information on insurance product offerings and enrollment forms and manage plan coverage elections at initial enrollment and during annual open seasons.

   Because the exchange will be responsible for serving as the plan administrator under federal law for participating employers, it will also need to perform certain regulatory compliance functions for those employers, such as creating and distributing to participating employers and workers the summary of plan benefits required by federal law that details the coverage choices offered to participating workers. The exchange can also be instructed to issue certificates of prior creditable coverage to individuals who subsequently cease to be covered under plans offered through the exchange—for example, individuals who move out-of-state or who take new jobs with employers that offer their own traditional group plans. To the extent that an exchange performs these functions, it becomes more attractive to employers and carriers because it relieves them of the effort involved in complying with those federal requirements.

   The preferred way to finance these core functions is with a fixed fee added to the premiums of the insurance purchased through the

1. Ideally, an exchange should service a single, inclusive market, open to all consumers and employers, regardless of firm size. An exchange should serve as an administrative mechanism to implement state insurance market reforms that create a broad, consumer-choice health insurance market. An exchange can also be a mechanism for administering government subsidies to obtain private health insurance, for aggregating employer and employee contributions to health plans, for disseminating price and quality information, and for processing premium payments, paperwork, electronic transactions, and other administrative functions. For a brief description of the concept, see Robert E. Moffit, Ph.D., "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *www.heritage.org/research/healthcare/wm1230.cfm.*
2. For a brief discussion of the Massachusetts reform, see Nina Owcharenko and Robert E. Moffit, Ph.D., "The Massachusetts Health Plan: Lessons for the States," Heritage Foundation *Backgrounder* No. 1953, July 18, 2006, at *www.heritage.org/Research/HealthCare/bg1953.cfm.*

exchange. As these administrative costs are largely fixed, the size of the fee will diminish somewhat as the number of enrollees in the exchange increases. The initial experience in setting up the Massachusetts Connector and earlier small business pooling arrangements indicates that a good rule of thumb is to estimate these costs at about 2 percent to 2.5 percent of average premiums for the initial years, with a somewhat declining share as the number of enrollees in the exchange increases.[3]

2. **Premium Payments:** Premium payments are pass-through financial transactions; as such, their size and volume have virtually no effect on operating costs. Also, estimated premium costs will largely be a function of the insurance market rules (e.g., rating parameters) set by state law. While it is important to model premiums to determine how reforms will affect health care costs and coverage, that modeling is largely tangential to determining the administrative costs of an exchange.
3. **Producer Commissions:** Commissions paid to agents and brokers are also pass-through transactions for the exchange; and again, their size and volume will have little effect on operating costs. Commissions compensate agents not only for bringing business to the exchange but also for providing benefits counseling services to enrollees, such as helping them pick the plans that best suit their preferences and circumstances. The exchange simply administers the commission arrangements in accordance with state law.
4. **Governmental Functions:** As noted, it is possible, though not necessarily advisable, for state lawmakers to vest a health insurance exchange with governmental or quasi-governmental responsibilities. These might include functions such as designing a payment scale for low-income subsidies or conducting eligibility verification for Medicaid or SCHIP applicants. In some cases, state lawmakers may have good reasons for outsourcing a governmental function to a health insurance exchange. For example, they may want the exchange to serve as a clearinghouse not only for private insurance plans but also for government programs, as a way to promote coordinated coverage. If lawmakers choose to outsource any governmental functions to an exchange, they should pay for those functions separately, out of the state's budget—the same as any other government functions. It would be unfair to those purchasing coverage through the exchange if they were the only ones charged for governmental services provided to the broader public.

   Massachusetts lawmakers overlooked this point, and so one flaw in the Massachusetts legislation is that the Connector is required to pay the state Medicaid department for the costs of determining premium support eligibility and administering payments for individuals receiving subsidies to buy coverage through the Connector. That is not how other states should structure any such arrangements. If an exchange is to perform functions that would normally be performed by a government agency, then it is only fair for the state to pay for those services out of its own budget.
5. **Startup:** As with any new venture, a state health insurance exchange will cost money to create. This expense will vary depending on the functions assigned to the exchange. States will need to budget for the startup costs of the exchange's core functions and include additional, separate budget items for any additional functions lawmakers delegate to the exchange. Because the core administrative functions of an exchange are virtually the same as those of a small-business pool that offers individual choice of coverage, past experience with some small business pools offer a good starting point for estimating startup costs of a state exchange. One successful pool, New York's Health Pass, had initial startup costs of $1 million in the first year and $3 million

3. Personal communications with Jon Kingsdale, Executive Director of the Massachusetts Health Insurance Connector; Vince Ashton, Executive Director of New York Health Pass; and Ken Comeau, Vice President of the Connecticut Business & Industry Association. The "percent of premium" method should be used only as a simplified estimating convention. Actual administrative costs should be charged on a fixed, per-enrollee basis.

more over the next four years.[4] The startup costs for a new exchange might even be somewhat less if it can pay to copy or use the administrative systems previously developed by an existing exchange or small business pool.

There are several possible sources for startup funding. The obvious option is a one-time appropriation by the state government. Other possibilities include a line of credit from the state or borrowing authority, with the funds loaned to set up the exchange repaid out of future revenues from the administrative fees charged to enrollees. Another possibility is to secure startup funding from philanthropic foundations. Indeed, in some states, grant-making foundations that focus on health care were created and funded out of the proceeds from the sale of a nonprofit health insurer or medical center.[5] Tapping those funds would be consistent with the public purpose and mission of those foundations.

Finally, it should be noted that many of the functions of an exchange—both core functions and any additional roles lawmakers assign to the exchange—can be competitively bid out to private vendors with relevant expertise, such as third-party administrators, benefits consulting firms, payroll servicing firms, and data management firms. In any case, state officials should seek assistance from these firms in developing cost estimates for the creation and operation of an exchange.

The ongoing costs of running a state health insurance exchange will be quite low, approximately equivalent to the administrative costs incurred by the human resources department of a very large employer for administering its workers' health benefits. Indeed, a good starting point for calculating ongoing expenses is the state government's experience administering health coverage for state workers. Furthermore, if the state government initially joins the exchange as an employer, then those functions could effectively be privatized into the exchange along with their current funding.

Conclusion. Unlike other areas of health care, the administrative functions that a health exchange is designed to handle are subject to economies of scale, and through the exchange, the benefits of those services and savings can be extended to a state's small employers, giving them something that they currently lack—a large, expert human resources department to manage their employee health benefit programs.

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4. Presentation by Vince Ashton, Executive Director of New York Health Pass, to the Delaware Public Policy Institute, June 12, 2007.
5. For example, the California Health Care Foundation was created out of the proceeds from the sale of California's Blue Cross plan.